# *Child Survival IX*

*(FAO-0500-A-00-3029-00)*

# *Malawi*

## *Final Evaluation*


***Submitted to:***

***United States Agency for International Development***
***Washington, D.C.***

***By:***

***Adventist Development and Relief Agency International***
***Silver Spring, MD***

***January 1997***

# Child Survival IX
# Nsanje District Malawi

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August 4- 16, 1996

Submitted to:

**Adventist Development and Relief Agency International**

by

**Lester N. Wright, MD, MPH, Consultant**

# LIST OF ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| ADD | Agriculture Development Department |
| ADRA | Adventist Development and Relief Agency |
| AIDS | Acquired Immune Deficiency Syndrome |
| CBD | Community Based Distribution (of contraceptives) |
| CDD | Control of Diarrheal Diseases |
| c s | Child Survival |
| DHO | District Health Office |
| DMO | District Medical Officer |
| DIP | Detailed Implementation Plan |
| EBF | Exclusive Breast-feeding |
| EPI | Expanded Program for Immunization |
| FP | Family Planning (also called Child Spacing) |
| GM | Growth Monitoring |
| GOM | Government of Malawi |
| HA | Health Assistant |
| HC | Health Center |
| HI | Health Inspector |
| HIS | Health Information System |
| HIV | Human Immunodeficiency Virus |
| HP | Health Post |
| HSA | Health Surveillance Assistant |
| IEF | International Eye Foundation |
| KAB/P/C | Knowledge, Attitude, Belief, Practice, Coverage (survey) |
| MOH | Ministry of Health |
| NGO | Non-Governmental Organization |
| ORS | Oral Rehydration Solution |
| ORT | Oral Rehydration Therapy |
| PHC | Primary Health Care |
| PVO | Private Voluntary Organization |
| RHO | Regional Health Office |
| STD | Sexually Transmissible Diseases |
| TBA | Traditional Birth Attendant |
| TH | Traditional Healer |
| TT | Tetanus Toxoid |
| U5 | Under Five |
| UNHCR | United Nations High Commission for Refugees |
| VHC | Village Health Committee |
| VHV | Village Health Volunteer |
| WCBA | Women of Child Bearing Age |

# EXECUTIVE SUMMARY

This Child Survival project in the lower Shire River valley, northern Nsanje district of Malawi, is the extension and expansion of a CS VI project. The area is remote and rural, with several small trading centers, one partially-paved major road, twice-weekly train service, and few other roads. The area has been heavily impacted by drought, and by the extended presence of Mozambique refugees in the early part of the service period. In one of the least developed countries in the world, this is the district with the highest reported infant mortality rate (19 1 per thousand), less education, and a lower level of development.

This project evaluation team consisted of a preventive medicine physician experienced in health programs in Africa (team leader), a public health administrator, ADRA-International Director of Evaluation, ADRA/Malawi Country Director, the Project Director, MOH staff (district family planning officer and a health inspector from the project area) and a staff member from an NGO operating nearby. The project evaluation included service record reviews, field observations, a survey of the target population, and a review of project financial records. The population survey and financial review were carried out under the direct supervision of ADRA-International, and are incorporated into this report. The service record reviews and field observations were conducted by the evaluation team on site in the project area and at the project headquarters. Project managers, supervisory and training staff, Health Surveillance Assistants, Village Health Volunteers, Village Health Committee members, village headmen, and community members were all interviewed individually or in groups. Team members used an outline questionnaire to assure that important areas of interest were not neglected. Villages and health sites selected for field observation were widely distributed throughout the project area, and were representative of both the most and least advanced in project activities.

This CS project has had a positive impact on the health of mothers and infants in the project area, as reported by community members, MOH staff and project staff. It has catalyzed community organization for health improvement. Though not all objectives were achieved, increased use of contraception, increased interest in child health, increased vegetable gardening, and general interest in sanitation are documented through project reports, the community survey and the evaluation field observations. The planned incorporation of project Health Surveillance Assistants into the MOH began ahead of schedule, and assures at least minimal sustainability for the project.

The evaluation report contains a number of lessons learned, most important of which are related to the need for consistent planning for project closure from the onset, and the important role community structures, e.g. village headmen and Village Health Committees, traditional healers and religious leaders, must play to achieve project success. The participation of the Project Director on the evaluation team facilitates the use of the evaluation results in the fmal weeks of the project, and increases the likelihood that lessons learned will be transmitted to those involved with efforts to sustain health improvements in Nsanje district.

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# EVALUATION

## I. Introduction and Background

This project is an extension/expansion of a Child Survival VI project located in the lower Shire River valley in the northern half of Nsanje District, the southernmost district in Malawi. During the earlier Child Survival VI project, the area was heavily impacted by refugees from political instability in Mozambique which borders the project area on both east and west. The refugees have returned to Mozambique during the life of this project. With them have gone much of the social support which was established to deal with their problems. Since the indigenous population and the refugees are of the same ethnicity, it is likely that some services meant for refugees were accessed by Malawians. These services that are no longer available. In addition, some project services may have been accessed by Mozambicans. It is acknowledged that some "visitors" still cross the border and access services in Malawi.

The project area has been heavily impacted by years of drought with interspersed floods in some parts of the area. The current year has brought weather that has been more favorable for agriculture.

The project area is remote and rural with several small trading centers. It is served by one major road that is partially tarmacked, a rail line with twice weekly service, and a few other unsealed roads. Travel to many parts of the project area is done only with difficulty by four-wheel drive vehicle on paths or by motorcycle, bicycle or on foot. The project area includes land on both sides of the Shire River and extends from Tengani to the northern boundary of the district, near Sorgin. The area includes approximately half of the district population of over 200,000.

Nsanje District is remote from the population and development centers of the country. It is generally less developed and its people have less education than the national average. Nsanje District has the highest infant mortality rate in Malawi, 19 1 deaths per thousand (Situational Analysis of Poverty in Malawi). Most of the population of the project area are engaged in subsistence farming, growing maize, sorghum, millet and sweet potatoes. According to WHO/MOH estimates, over half of the existing housing provided poor protection against bad weather. The area is a low altitude river plain with surrounding foothills where daytime temperatures can reach the mid-forties (C).

Malawi is one of the least developed countries in the world. In 199 1 the estimated GNP per capita was US$230. Inflation was 22.7% in 1992 while the GDP fell 7.9%. Real income of the majority of the population has deteriorated in recent years. The rate of exchange against the US dollar fell from approximately 4.3 Kwacha per dollar at the start of the project to approximately 15 Kwacha per dollar at the time of the mid-term evaluation. That rate of exchange has held essentially steady for the final half of the project, however. The rate of

inflation, which was 80% for part of the project period has now fallen to 50% according to local business sources. A multi-party election was held in May 1994 resulting in a change in government, the first since independence. The election and hand-over of power were accomplished with relatively minor disruption of the life of the project area's population and only moderate detrimental effect upon the project, and most of that was short term although some bitterness persists in some villages. The current GOM is supportive of the goals of Child survival.

Although women have equal legal rights in Malawi, there are many constraints to advancement of women. Strong sociological and cultural forces maintain and enforce women's inferior position. Child bearing is considered essential and Malawi has one of the highest crude reproduction rates in the world. The illiteracy rate for women was estimated to be 7 1% in 1987 (compared with 52% illiteracy rate for men.) According to the project's final survey, conducted in July 1996, 83% of the mothers of children under the age of two years surveyed self-report as illiterate and 1.7% have more than a primary school education. This is not significantly different from the 80% reported illiteracy and slightly better than the 0% who had more than a primary school education reported on the mid-term survey. The current GOM has begun to offer free primary education for all children, so this situation is likely to change in the relatively near future. The desire for adult literacy classes was expressed in several of the focus groups of mothers interviewed during this final evaluation.

The Child Survival IX project was planned to expand into the 20% of villages in the catchment area that were so remote they had not been served by CS VI. In addition to serving these areas, the CS IX project was planned to include adding two new interventions, HIV/AIDS and Family Planning.

# II. Project Design and Implementation

The project was designed as a community-development primary health care model, expecting mothers to be the primary care givers for their families. The project focused on educating and motivating mothers to use available interventions that can decrease the major causes of neonatal and infant mortality. They were encouraged to use existing but enhanced community services.

Community-based Village Health Volunteers (WV) were selected and trained for service in each village in the service area. In addition, each village selected a ten person Village Health Committee (VHC) which usually includes the village headman. Health Surveillance Assistants (HSAs) serve as liaison between the MOH and the project and villages. HSAs were trained by project trainers and supervised by the trainers and by MOH Health Inspectors and Health Assistants. The HSAs then trained and supervised VHV and regularly met with VHCs. All levels were linked together by training, supervision and monthly reporting of health data and project activities. As part of its institutionalization, HSA monthly reports were reviewed by MOH supervisors.

In addition to training VHV and VHC, project staff have expanded their training to traditional birth attendants, traditional healers and religious leaders of the catchment area. This has led to invitations for HSAs to present health messages at church convocations and camp meetings and to present health messages including AIDS prevention messages at funerals. The latter is particularly important since it is common cultural practice in the catchment area to require "sexual cleansing" of the widow of a man who has died. Traditionally this is done by sexual intercourse between the widow and an anonymous man hired for the purpose.

# III. Evaluation Methodology

## A. Team Composition

The evaluation team consisted of the team leader, a preventive medicine physician who has spent a number of years working in health programs in Africa; an experienced public health administrator who is currently professor of health policy in a nursing school; the ADRA-International Director of Evaluation; the ADRA/Malawi Country Director; the Project Director; the MOH Southern Regional Family Health Officer; a health inspector representing the MOH Nsanje District Environmental Health Officer; and the family planning and STD Coordinator for a NGO operating in an adjacent District.

## B. Field Work

Members of the evaluation team spent five days in active field observations. The team first interviewed MOH officials at the District Health Office at Nsanje Hospital. Then, to maximize effectiveness, the evaluation team divided into two. Half of the evaluation team focused on the west side of the Shire River and the other half on the east side. Each team visited health centers/health posts where they discussed the local health situation and the project with resident staff as well as visiting villages. In the villages they held discussions with mothers, VHC members, VHV, HSAs serving the village and village men. Depending upon numbers in each of the above categories, the teams conducted as many as four simultaneous focus groups in each village. In a number of villages the team was presented with a health-focus drama and/or song. These well planned and executed activities readily demonstrated villagers' familiarity with health education messages that the project had provided. Villages were chosen to be representative of the entire project geographic area including the more remote areas first served by CS IX. Villages were also representative of those which are most and least advanced in project activities. Members of the east side team interviewed staff at Trinity Hospital; members of the west side team interviewed staff at Kalemba Parish Clinic in Bangula.

Project managers, supervisory and training staff were interviewed individually in their catchment areas of service. Project records and policies were reviewed at the Project headquarters in Ngabu as well as at the ADRA/Malawi office in Blantyre.

Team members were asked to conduct semi-structured interviews using an outline questionnaire to assure that important areas were not neglected. After each day of field work the entire evaluation team gathered to debrief and discuss observations and lessons learned and identify specific areas for more in depth explorations on following days. In a final session, the team as a whole discussed major findings and developed its list of lessons learned and recommendations.

### C. Observations

An extensive discussion of the field observations of the evaluation team is included in Appendix C of this report.

### D. Final Survey

A final survey was conducted immediately prior to the evaluation. One member of the evaluation team, the AD&A-International Director of Evaluation, participated in the survey. Findings from the survey are used, where appropriate, to assess project accomplishments in meeting stated objectives. Survey methodology and findings are described in Appendix E.

# IV. Project Accomplishments

### A. Imdementation

The project DIP projected that during the life of the project 20 ADRA HSAs and 32 MOH HSAs would receive training and carry primary responsibility for training 450 project VHV serving some 160 villages. The latest monthly report available, covering the period of 14 May to 15 June 1996, was compiled from reports submitted by 2 1 of 23 HSAs said to be active in the project. Eleven of the reporting HSAs are ADRA HSAs and 10 are MOH HSAs. They reported 449 VHV serving 197 villages. According to the Second Annual Report, each village has a VHC.

### B. Context

Every project is carried out within an ever-changing context. Some of the changes aid the project in meeting its objectives, some hinder. This project is no exception. The evaluation team identified several circumstances within the country and within the project catchment area that may have affected the project's meeting of its objectives.

The political changes which occurred in Malawi over the course of this project have had a substantial impact. The energy devoted to political campaigning at the local level consumed leadership attention that would otherwise have been available for project activities. Further, in the campaign speeches preceding the election of a new government two years ago, candidates

made promises about pay for all work, ending a system of government-enforced unpaid community service labor. This undercut the attractiveness of voluntary positions such as those for VHV and for VHC membership. A strong positive impact, however, has been the new openness to public discussion of HIV/AIDS and family planning.

Two changes in financial policy influenced this project in a number of ways. Allowing the value of Malawian currency to float in relation to other currencies left the project with an unexpected budget surplus, as fixed salaries could be met with fewer US dollars. The unexpected funds were re-directed to meet transportation and training costs which were disproportionally increased by the change in currency value and by the need to maintain consistency with MOH allowances for training, but there were many months of very confused budget development.

At approximately the same time, transition to decentralized government budget and spending authority left the MOH unable to purchase needed vaccines and supplies or parts for bicycles, unable to supply reliable transportation and unable to commit to a specific schedule of hiring for HSAs.

The severe drought during the early project period markedly increased health problems in the target communities. While the weather during the current year has been favorable, time was lost as villages struggled to find sufficient food. Village structure was disrupted, and leaders who would otherwise have been the nucleus of strong VHCs were forced to work on survival, often leaving the area to find food.

The presence of large numbers of Mozambican refugees added to the difficulties. At the time that the project began there were more refugees than Malawi residents in the project area. Some services were available only to refugees and the increased activity in the area supplied economic stimulus. While the refugees have returned home and the UNHCR staff have departed, some Mozambique residents continue to cross the border into Malawi for services.

The area has experienced a rapid increase in HIV infection over the course of the project. As mentioned above, it was not possible to hold extensive public dialogue about the issue at the outset of CS IX; now there is strong government interest in HIV prevention and home-based care for those with AIDS. ADRA itself has been able to start an AIDS project that has interacted with CS IX in the project area.

Finally, this project faced a change in director just past its midpoint. While this might have been expected to prove disruptive, the selection of an experienced Malawi national already very familiar with the project area made the transition a smooth one. By some measures, this level of local knowledge may have been a gain in developing community relationships and planning for transition.

## C. Actions Taken in Response to Recommendations from Mid-term Evaluation

**1. The project should continue negotiations with DMO for transfer of project HSA to MOH.**

Of the 23 HSAs who have been active in this project, 7 were attached from the MOH. Eight have been hired by MOH from the project. Eight more remain as employees of ADRA since they do not qualify for MOH hire because they lack academic certificates. Nsanje District has recently been authorized to hire 95 more HSAs and will shortly be advertising the positions and interviewing.

**2. The project should try to secure assurances that the HSA transferred will, as much as possible, continue serving the areas in which they currently serve in order to provide continuity for VHV and VHC.**

MOH agreed to leave HSAs in their same catchment areas. In addition, MOH is insisting that staff live in one of those villages instead of at the trading centers like many ADRA HSAs have done. The HSAs who have transferred from ADRA to MOH have been continued in their catchment areas.

**3. The project should prepare a set of recommendations for reprogramming money budgeted for HSA salaries that will be saved by early transfer of HSA to MOH so that money can be used appropriately to strengthen the effect of the project.**

This was done by the ADRA/Malawi Country Director, Accountant, and Project Director. Although salary expenses were considerably less than budgeted, training expenses were greater as were vehicle expenses. The project will end within budget.

**4. Some of the project money budgeted for HSA salaries saved by the early transfer of the HSA to MOH should be used for increased training of HSA in supervision of VHV; this could increase the likelihood that HSA will spend more time on community-based primary health care rather than simply in clinical services.**

Supervisory training was conducted with the assistance of HI from MOH as well as a trainer from IEF.

**5. The project should resist the natural attraction toward providing clinical services and always remember the public health focus on the community and its health.**

ADRA CS staff, District supervisors, and CS Advisory Committee did not feel this was a problem. Project staff were scheduled to spend one day a week in clinical services. This was felt to be needed to stay in touch with clinic personnel who serve the same clientele.

**6. The project should resume discussions with DMO about expanded use of revolving fund programs for supply of a few simple medications in the villages.**

MOH has had difficulty obtaining basic drug supplies for hospitals and health centers. Some villages did not see that it was their responsibility to pay for medications as needed to replenish the revolving fund. Therefore, evolving drug plans were postponed. They may be connected to Community Based Distribution of contraceptives (CBD) programs in the future.

**7. The project should work with the family planning service provider and the DMO to expand CBD of contraceptives to more of the project area.**

Nsanje District MOH has taken the lead in CBD in the project catchment area and the project has promoted this program in the villages where it has been introduced. The NGOs who have worked with CBD in the catchment area have withdrawn.

**8. Single specialty project training/supervisory staff should concentrate on training throughout the project area rather than on delivering services in a limited area.**

The ADRA HSA specializing in STD/AIDS left to continue his education. A retired school principal who was working as an HSA for the project was moved to the position of Educational Consultant. Much of his time was spent visiting 40 schools in the catchment area to advise and encourage them in forming and conducting anti-AIDS clubs and implementing the newly introduced AIDS curriculum. The family planning worker has concentrated on those villages where CBD has been introduced, At the same time, all areas have had training on promotion of family planning. The gardening instructor has led demonstration gardens in a number of areas, has worked with primary schools developing gardening programs and has provided training in other parts of the catchment area.

**9. The project Manager should reactivate the Advisory Committee, reorganizing it if necessary.**

The Advisory Committee has been meeting. According the current Project Director who assumed his current position in January 1996, it has met twice during the first half of the year.

**10. To enhance visibility and communications, the project Manager should visit health centers/health posts and hospitals in the project area on a regularly scheduled basis.**

The Project Director has been visiting health facilities and villages in the area; this was evident from discussions at various field visit sites.

**11. The ADRA Country Director and the Project Manager should have regularly scheduled meetings, not called because of some emergent situation. They should also meet together with offkers of the Malawi Union of Seventh-day Adventists to discuss the progress of the project quarterly or semiannually.**

The ADRA/Malawi Country Director and the Project Manager have been meeting biweekly.

**12. The relationship between VHV and VHC should be clarified and strengthened.**

MOH has struggled with this relationship. In villages the evaluation team visited, it appeared that VI-IV and VHC are working together in a de facto relationship.

**13. The project should consider offering training to the VHC Chairmen together with and on the same terms as that offered to VHV. This could increase understanding between them and collaboration.**

VHC Chairs were invited to attend CS training on malaria prevention and prenatal care. During more recent training, each VHC was invited to send two members.

**14. The project should provide training in project interventions to traditional birth attendants, traditional healers and leaders of faith communities (churches and mosques) and enlist their support in communicating them to the communities served.**

The project has conducted training for TBA, TH and leaders of the faith communities. This was reported to have been met with considerable interest and success and has led to additional invitations to conduct health promotion at church sponsored meetings and at funerals.

**15. The project should develop and offer training in simple data analysis for HSA; this could be available also to HI and HA if indicated.**

HIS training for HSAs was conducted at a regularly scheduled monthly meeting. The topic was also covered at a ADRA/Nsanje District meeting attended by all catchment area HA and HI.

**16. Mechanisms to reinforce the importance of sanitation, such as annual "Clean Village Competitions," should be instituted.**

According to the January - March 1996 project quarterly report, a prize is being offered "to the village which will build more pit latrines and keep the village clean."

**17. The pilot preschool/preparation for primary school entry program should be structured to maximize use of health materials as media for instruction and should include organization of mothers into "parent support groups" to involve them as well.**

The CS Educational Consultant conducted monthly meetings with parents of children in the pilot project's three pre-schools. The small scale pilot was not funded further and discontinued after the change in Project Managers.

**18. The rapid and radical change in exchange rate of the Kwacha v. the US% mandates that the project budget be regularly reanalyzed to keep it realistic considering the varying effect of this changing rate on various components of the budget.**

The exchange rate has remained essentially stable through the final half of the project.

**19. ADRA-International should provide additional backup to the ADRA-Malawi accounting staff on dealing with the problems of accounting and budgeting in a time of rapid currency value change.**

ADRA-International provided consultation and a revised average exchange rate to deal with the currency value change.

## D. Unintended Positive and Negative Effects

Every project has effects upon the communities and individuals it strives to serve. Some of the effects are intended, i.e. progress toward meeting project goals and objectives. Other effects are unintended. The evaluation team identified several unintended effects of project activities.

### 1. Positive Effects

Of the unanticipated outcomes of the project, the strongest noted is the identification of community strength and structure which cuts across sectors. From the base of the VHC, focused on children, communities have understood the need for and requested safer water supplies and latrines, made vegetable gardening an income generator and have begun to request kindergarten and adult literacy classes. The self-ownership of health as a village concern was made clear in many (though not all) of the communities visited by the evaluation team.

ADRA was pulled into several newly identified projects through CS IX. These included finding resources to construct two health posts in previously unserved villages, a project to construct pit latrines (now very visible in many villages) and the purchase of seeds to start vegetable gardening. In addition, during the flooding which followed the drought mentioned earlier, disaster assistance and clothing were made available in the area.

While the MOH, ADRA and other NGOs have operated in overlapping areas, this project provided the impetus for improved collaboration. Examples of this include ADRA's provision of bicycle repair for all health-related bicycles in the area during the MOH budget difficulties, and the MOH working with NGO's to develop common monthly work plans to avoid duplication of effort at the community level.

The effects on traditional practices are diffkult to assess at this point, but appear to have been mixed. The opportunity for women to gather for Under-5 (U5) clinics has allowed a level of interaction not regularly found in these communities, and allows for reenforcement of positive messages. Some traditional practices hazardous to health, e.g. sexual cleansing practices which contribute to the spread of HIV, have been changing more rapidly in some parts of the catchment area than expected.

### 2. Negative Effects

One potentially negative consequence of the interest in community self-ownership of health is a demand for technology beyond the level that is sustainable at the present time in this area. This is evidenced, for example, by the request for boreholes, but only those which are machine-dug. Shallower boreholes have not proved reliable in alternating drought and flood. In addition, without local capacity for maintenance, many boreholes have ceased to function.

The movement of former ADRA Health Surveillance Assistants to MOH positions, while extremely positive, may have the short-term impact of over-extending MOH capacity to provide adequate supervision.

Some communities report that men's response to increased interest in family planning on the part of women has been less than positive, including threats to take another wife if a woman begins using contraception. VHV report mixed success challenging these. reactions.

# V. Project Goals and Objectives

The goal of Malawi's Child Survival IX project is to decrease mortality and improve the quality of life for low income mothers and children in the northern half of Nsanje District, the southernmost district in Malawi. Project objectives include:

## A. Nutrition

**1. 80% of WCBA will have received instructions regarding nutrition during infancy and childhood.**

No direct indicator data have been collected to monitor this objective. According to the first annual report "80% of VHV received this training by 5/31/94;" training records do not give further detail.

**2. High baseline levels of appropriate infant feeding practices have been maintained. 40% of mothers with infants less than four months are practicing exclusive breastfeeding.**

At baseline, 2.5% of mothers with children under 4 months of age reporting exclusively breastfeeding. According to the June 1996 monthly report, 16% of mothers of children under that age of two reported exclusively breastfeeding. In the final survey, 91.9% of mothers with infants less than four months of age reported that they were currently practicing exclusive breastfeeding. Assuming an equal distribution births by four month period, relatively low mortality and most exclusive breastfeeding during the first few months of life, these data are consistent. Thus, according to the final survey, this objective was met.

**3. 60% of WCBA will increase their food intake during pregnancy.**

According to the final survey, 18% of mothers reported eating more than usual during their last pregnancy. The proportion of mothers who reported eating less than usual during their last pregnancy fell from 64% to 55% from the baseline to the final survey. It is unclear why this objective was not met since the health message was reported to have been given and crops have been better this year than in several previous years.

4. 80% **of pregnant/lactating women will receive a single dose of Vitamin A within four weeks of delivery and 80% of [children] 6-72 months will receive a maintenance dose of Vitamin A every six months.**

Final survey data show that 68% of mothers reported having received a single dose of supplemental Vitamin A during their pregnancy. The timing of this dose was not identified by the survey, so it is not possible to determine what proportion were given during the four weeks prior to delivery. This objective was not met although a high percent of mothers did report having received supplemental Vitamin A during their most recent pregnancy.

According to the final survey, 91% of children 6-23 months of age have received Vitamin A and 99% of children under 2 years of age with a growth card have received Vitamin A supplement within the last three months. This objective was met for those 6-23 months of age. No data were collected regarding those from 24-72 months of age.

5. 50% **of households with WCBA will have a vegetable garden.**

According to the June 1996 monthly report, 52% of families of children less than two years of age have a vegetable garden. This proportion varies on monthly reports according to the season. According to the fmal survey, 90% of mothers of children less than two years of age have a vegetable garden. The reason for the discrepancy is unclear, but the survey may have measured prevalence of gardens during the year rather than at the point of the survey. This objective was met.

## B. AIDS Prevention

1. **100% of HSAs and volunteers have received training in HIV/AIDS prevention and counseling.**

According to training reports, 100% of HSAs are reported to have received this training. According to the first annual report, "80% of VHV received training in STD/HIV/AIDS education;" training reports do not give further detail.

2. 80% **of VHCs have been trained in HIV/AIDS prevention in the community.**

No data are available on what percent of VHCs have received this training.

3. 90% **of target population age 15-45 know HIV/AIDS high risk behaviors and appropriate preventive behaviors.**

According to the final survey, 90% of the target population know at least one high risk behavior for HIV infection and 87% know at least one appropriate prevention behavior. In both cases, the question allowed for multiple responses; since it is unlikely that only those knowing the highest response rate behavior knew any behavior, it is likely that the actual percent that knew appropriate behaviors exceeded that for the highest single behavior. Thus this objective was substantially met.

**4. 20% of target population age 15-45 report having sex with only one partner.**

This objective is fraught with potential bias since few people are likely to openly admit having multiple sexual partners even when that is the case. The June 1996 monthly report indicates 8 1% of mothers of under two year old children reported being faithful to one spouse. The final survey shows 52% of this target population reported that in order to protect themselves from getting HIV/AIDS they have been faithful to their marriage partner. The length of persistence of this behavior is not indicated. The discrepancy between these results is not readily explained. This objective was reported to have been met.

## C. Growth Monitoring

**1. 80% of O-11 month old children will participate in a monthly growth monitoring program.**

According to the final survey, 91% of children O-l 1 months had growth cards and 65% had been weighed during the last month according to the card. All children in this age group had been weighed within the past two months. This objective was not met but allowing for clinic schedules and vague definition of what the "last month" meant, it appears to have been substantially met.

**2. 50% of 12-23 month old children will participate in a growth monitoring program every three months.**

According to the final survey, all 12-23 month old children have been weighed within the last two months. Thus this objective has been surpassed.

## D. Family Planning

**1. 80% of the VHCs will have received instructions regarding the importance of and methods of family planning.**

No data are available on what percent of VHCs received this training.

**2. 100% of volunteers trained in Family Planning counseling.**

According to training reports, 26% of VHV were trained in 8 training sessions on family planning counseling; 57% of HSAs received this training. According to the second quarterly report of the second year, "complete training of all VHV" in family planning was accomplished by 3/31/95; training reports do not give further information. It was the observation of the evaluation team that family planning was being discussed in most or all of the villages visited, so the training reports may be incomplete.

**3. 25% of those desiring no more children are using a modem method** of **birth spacing.**

According to the final survey, 26% of mothers desiring no more children are using a modem method of birth spacing. It is consistent with the June 1996 report of 23%. This is a substantial increase from the 9% reported at baseline. This objective was met.

## E. CDD

**1. 80% of O-23 month old children in both remote and non-remote areas will receive appropriate home management in diarrhea1 episodes including increased fluids, increased feeding, and appropriate care seeking.**

According to the final survey, diarrheal episodes were dealt with by increasing breast feeding (5 l%), giving increased amounts of fluids (46%), giving more food (50%), and appropriate care seeking (52%). These answers were not exclusive. When ORS was included in the multiple answer tabulation, 80% were included. This objective appears to have been met.

## F. EPI

**1. 85% of children 12-23 months of age in both remote and non-remote areas will have been fully immunized.**

According to the fmal survey, 66% of 12-23 month old children have been fully immunized. These data are not separated by area of residence. Since immunizations are dependent upon supplies and MOH staff, it is unclear why this objective was not met, or whether it was within the control of the project or not. This objective was not met.

**2. 60% of WCBA have received at least two TT doses.**

According to the final survey, 82% of the 55% of WCBA who had maternal health cards had received at least two TT doses. This indicates that at least 45% of WCBA had

received at least two TT doses. Since the proportion of WCBA who had maternal health cards is so low, it appears likely that at least some others who have been pregnant within the past few years have received at least two TT doses, so the actual rate may be higher than indicated in this survey. Ninety-two percent of mothers interviewed knew they needed 2 or more TT doses. This objective was not met.

## G. Literacy (Adjunct fund)

**1. 2000 WCBA have completed the basic functional literacy course.**

This program, to have been funded by an adjunct fund, was not funded or carried out.

## H. Changes in Project Design

1. **Malaria Prevention and Control.** According to the first annual report, it was decided to add a measurable objective on malaria control. The specific objective is not stated.

According to training reports, 52% of VHV and a large number of VHCs, TBAs, TH and religious leaders received training in malaria prevention.

2. **Women in two remote areas will have access to trained TBAs. This** objective was reported on the second annual report to have been added.

The two remote areas are not identified. According to training reports, 9 TBAs received prenatal care training.

3. **80% of WCBA will have received instruction regarding the importance of prenatal care and delivery by a trained person.** This objective was reported on the second annual report to have been added.

No data were collected which measured this objective directly. According to the final **survey, 98%** of mothers of children under the age of 2 years knew that it is important to receive prenatal care sometime during pregnancy; 94% reported having received ante-natal care; 54% (98% of the 55% with maternal health cards) had at least one ante-natal visit recorded.

4. **400 preschool children will have completed an introductory eight week course in reading, arithmetic, and health.** This objective was reported on the second annual report to have been added.

No data were recorded regarding this objective.

5. **Delete Literacy Objective: 2000 WCBA complete basic functional literacy course.** This objective was reported on the second annual report to have been deleted because funding was not forthcoming and World Vision had begun a similar program in part of the catchment area.

## L. Management, MOH Systems & Local Community Systems Strengthening

1. **Staff have been involved in developing, understand and are monitored by project work plans.**

Staff job descriptions are present. Quarterly and annual work plans are evident in quarterly and annual reports.

2. **There is general participation in & satisfaction with VHV by community members.**

According to the June 1996 monthly report, 56% of VHC met as a group and 64% of VHVs met with VHCs. Discussions by the evaluation team with focus groups in villages and with workers at health centers and health posts confirmed that most VHC are active although many do not have ten members who are active. All villages visited had VHV and the level of interaction and satisfaction appeared high.

3. **MOH is utilizing a service quality monitoring system for services related to project interventions.**

Evidence of the use of a service quality monitoring system was not readily available; supervisors and HSAs report that regular supervisory visits are being made.

4. **HSA, HC/HP staff have been given refresher training in specific interventions.**

Quarterly and annual reports indicate that HSAs receive regular inservice education including refresher training on specific interventions targeted based upon weaknesses noted during supervision or reporting. At least some of the HSA inservice education occurred together with HC/HP staff

5. **ADRA staff are participating in regular professional upgrading activities.**

Quarterly and annual reports detail professional education courses attended by ADRA staff These are consistent with professional levels and project concerns.

# VI. Sustainability Issues

Evaluating the potential for sustaining the programs and positive impact of CS IX in the Lower Shire Valley was approached by asking inter-related questions of communities, the NGO and the Ministry of Health. Interpretation of the answers was informed by consideration of the lessons learned during this project, its unintended positive and negative consequences, and the circumstances which surrounded the projects.

## A. Community Participation

The participating communities have been involved since the origin of the project, in the selection of VHCs and VHVs. In the villages where the project has been most enthusiastically received and shows the most impact, the village headman has shown continuing interest in the project by attendance at training sessions, convening village gatherings to implement training, and encouraging volunteers in their efforts. At one village demonstration of use of drama to present a health message, the headman participated in the drama, playing his own role of inviting the VHV to educate his village. General feedback received during evaluation field visits indicates that most headmen will continue in their general encouragement of VHCs and volunteers and supporting implementation of learned improvements.

A method for the identification and training of replacement volunteers over time was not built into the project from the outset, and has not been anticipated at the village level. From comments received, village headmen will be prepared to name replacements as needed, but the training will have to be provided in some way.

The high level of interest in receiving additional training indicates that this would be successful. For example, several villages indicated specific interest in receiving sufficient training to maintain their own boreholes (either one already in place, or the one they hope to receive).

## B. NGO Ability and Interest

### 1. ADRA

ADRA has clearly stated an interest in this project's transition to other sources of support. The final weeks of the project will include meetings with MOH at the District and Regional levels. Some form of joint interaction with HSAs, VHCs and volunteers to signify the end of CS IX and the assumption of responsibility by MOH has been discussed, and would assist all involved to refocus on the MOH as the continuing point of leadership. To the extent they are useful, training materials and other *resources* developed by ADRA for this project will be made available to the MOH.

While CS IX is ending in this part of the country, ADRA has two other projects in the area: latrine installation and AIDS. It is possible that some of the infrastructure of these projects can be directed toward ongoing support for the villages or the HSAs. Because this project has stimulated village interest in other improvements (water supply, latrines, literacy and economic development were all mentioned in one or more villages), ADRA will make an effort to assist communities in mobilization and resource development to meet highest priority needs. Assisting communities to participate in a newly identified program to supply solar panels to power vaccine refrigerators is one example of this approach. Meetings with other NGOs working in the area may surface other existing or potential resources as well.

Because an abrupt severing of contact with the project participants could be interpreted as undercutting sustainability, ADRA wishes to show on ongoing interest. One approach being explored is that of working with the MOH to return in one year to conduct a follow up field visit similar to this end of project evaluation. Announcing this intent in advance would be a strongly positive signal of interest in continuity.

### 2. Other NGOs

Trinity Hospital, which serves the eastern shore of the Shire River, has a long-established interest in primary health care. It used volunteers in its program before CS IX began and some of those volunteers became VI-IV in CS IX. It will continue to use volunteers. They provide the same MOH standard training allowance as ADRA has provided. It is likely that VHV in villages served by the Trinity Hospital primary health care program will be incorporated into their program.

World Vision has a community development project in part of the catchment area of CS IX. It is likely that their project will continue to build on and support community involvement that has been the core of CS IX.

International Eye Foundation has provided Vitamin A intervention in the CS IX project catchment area in the past and provided training assistance during CS IX. IEF continues to operate in an adjoining district. It is likely that they would continue to assist with Vitamin A interventions in the project area.

Leaders of faith communities have been supportive of CS IX activities and congregation leaders have received training in some project interventions. Faith communities could play a significant role in encouraging VHVs and VHCs to continue their efforts and reinforcing their messages. The Seventh-day Adventist church leadership expects its clergy to encourage and reinforce volunteers in continuing the project's emphases and is interested in following up on the reported interest in adult literacy classes using health media.

### C. Ability and Willingness of Ministry of Health to Sustain Activities

From the perspective of the Ministry of Health, a major portion of this project has already achieved sustainability, through the transfer of all CS IX-trained and employed Health Surveillance Assistants who meet academic requirement of MOH to MOH positions and payroll. The MOH has kept these workers in the communities with which they are familiar, and has recently received hiring approval for enough positions to absorb the reminder still on project funds. The position description for HSAs includes responsibility for training of VHCs and for work with the VHV. Some of the support for VHV may be appropriate self-interest, as the volunteers can be of substantial assistance supporting the HSAs in their regular data collection responsibilities. The MOH has a regular program of training for HSAs that will continue, and that includes topics central to CS IX.

Procedures to identify and train replacement VHVs and VHC members have not been established. Such attrition will occur. It should not be an overwhelming burden but must be included in the job descriptions of HSAs and their supervisors.

In addition to the human resource support provided, the MOH is committed to increasing supplies at the local level, such as in the CBD for contraceptive supplies. This system is already in place in some of the project villages, and will be expanded as resources become available. A trial program to make malaria drugs available at the village level through a revolving purchase program could also be expanded. Since malaria is one of the most frequently mentioned health problems in the area, community interest in this option may be very high.

# VII. Project Expenditures

(See Appendix F)

# VIII. Lessons Learned

### A. Plan for project end from the beginning.

The design for transition from project to locally sustainable activity should be in place explicitly and continuously from the beginning of the project. During the final evaluation visit, some village leaders expressed surprise that ADRA would no longer be working with their VHV and VHCs. Although some of the VHV had come from a Trinity Hospital primary health care program and were expected to return to that program, management staff at Trinity Hospital were unclear on the transition to MOH oversight and the impact this might have on volunteer training. The fact that transition of some HSAs from ADRA to the MOH occurred well in advance of the end of project is seen as very positive, and is facilitating transition. Retaining HSAs in the same areas served while on ADRA support assures local continuity. In the same manner, the fact that

HSAs and volunteers from ADRA and MOH have been attending common training activities has been useful. Building on these strengths, making them more explicit, and sharing documentation of transition plans widely would have made a stronger project.

### B. End of Project events can enhance continuity.

Projects should plan specific end of project events at HC/HP and in villages to signify and reinforce the transition and continuity. Volunteers can be given recognition and their ongoing training and supervision link can be reinforced. Villages can be recognized for their support and their community organizational involvement can be reinforced. These steps can enhance continuity.

### C. Involvement of Village Headmen helps assure success.

The most obvious important factor to success of project implementation identified by the evaluation team was a village headman who has been interested, involved and who participated in training and was seen as supportive of interventions after the training. Those who are involved had been sold on the importance of project interventions to the well being of their villages. In relatively traditional societies such as found in the project catchment area, the headman wields powerful influence. It would benefit any project to begin its involvement in its catchment area with specific efforts targeted to winning support of village headmen.

### D. Volunteerism is complex and requires careful nurture.

Issues of local leadership and local attitudes toward volunteerism are an important area in which lessons were learned or re-enforced. The need for early and positive involvement of local leadership was evidenced in the different levels of village knowledge and support, which appeared to be directly related to the degree of personal attention given this project by the village headman. The inclusion of headmen and VHC members in the training offered to VHVs extended the reach of the project. Further, the decision to include religious leaders of all faiths, traditional birth attendants and traditional healers in training increased reception of new ideas, and may be one reason for the apparently rapid movement toward family planning and away from some unhealthy traditional practices.

### E. Make full use of Village Health Committees.

Keeping the VHC actively involved with the volunteers was important. The fact that VHVs attended monthly training sessions, had identification badges and received some token incentives such as occasional bars of soap may have led to dissatisfaction on the part of some committee members, and contributed to a perception by some others that "ADRA volunteers are paid". Volunteerism is clearly a complex issue, in which self-esteem, roles of leaders, potential for future employment and other dynamics play a part. Providing as clear a message as possible

about the role of self-help and voluntary action is an essential part of transition and sustainability for this type of project. For example, the MOH is opening up a large number of positions for HSAs, but lacks currently trained candidates. Some successful village volunteers with adequate academic certificates might be encouraged to seek additional training.

### F. Emphasize non-traditional learning approaches.

While Child Survival projects generally are intended for use in communities with limited literacy, there is a perception that a higher local literacy level is a contributor to project success. The use of non-traditional educational approaches such as drama and song were very useful, as were the pictorial messages widely distributed through the volunteers. Project leaders believe that working with all volunteers on three month long "message blocks" was also very useful, because it kept people focused, and allowed for reenforcement of messages across communities.

### G. Involvement of men is important to success of programs for women and children.

Child Survival projects have a target population of women and children. Interventions are directed toward women and children. Men can be left on the outside looking in. In relatively traditional societies, however, men still have very strong influence. Child Survival projects could benefit by specific educational efforts targeted at men. Men can be convinced that their own well being, not just the well being of their women and children, will be enhanced by project activities. They can be introduced to what will be taught so that suspicions that often persist in those who see themselves as being on the outside can be overcome.

### H. Vaccine boosters in older children can encourage infant immunizations.

At the time of the evaluation visit, a measles outbreak was occurring in parts of the catchment area. Most of the cases were reported to be occurring in older children, most of whom had received measles vaccine in prior years. MOH was providing small campaigns of measles vaccination in some of the outbreak areas when vaccine supplies were adequate (additional vaccine having been purchased by World Vision for villages being served by their community development project.) Although measles may be fatal less often in older children, it still causes serious illness. When villagers see measles present after they have understood vaccine would prevent it, they are less interested in getting immunizations for their infants. Thus booster immunizations may be essential to assuring that infants get their primary immunizations.

### I. Locate Droiect office in Droiect area.

At the level of project management, future projects should seriously consider locating the main project office within the service area. This project office was co-located with another PVO project a few kilometers away from the project area in an adjacent district. The added distance

on a very rough road was clearly a strain on project management. In addition, it may have undercut local identification of the project to some extent.

## J. Currency revaluation reauires constant budget attention.

Budget development and management need to be strengthened, especially for any project working during conditions of currency devaluation or fluctuation. The substantial underestimate of training costs and underestimate of vehicle maintenance costs was fortuitously covered by salary savings due to devaluation and a beneficial exchange rate. Such a condition cannot always be assured. In regard to the training costs, the decision was made to use the MOH per diem rate for trainees, but to hold training sessions monthly rather than quarterly or even less frequently as is the usual MOH standard. The frequent contact improved supervision, and allowed HSAs to get regular reports from VHVs to use in assembling health data. This frequency can probably not be sustained under MOH management.

## K. Assure a simplified Health Information System that collects data required for the proiect.

Monitoring of progress toward objectives, data collection and reporting should be seen as parts of a continuous process, and careful attention should be paid to making certain they are consistent with one another, manageable, and readily understandable. In the case of this project, there are some objectives about which no meaningful information was obtained. Neither the monthly reports from HSAs nor questions asked on the base-line, midterm and fmal surveys gathered the necessary facts. In those areas where appropriate data were sought, there was no system in place to summarize the information and present it to the project management in a readily readable format. The project's required Detailed Implementation Plan format may be so overwhelming that it is a distraction from clear attention to needed continuity in this area.

## L. Graphic display of data could increase its value to the project.

Graphic display of data could be useful for even those with minimal understanding of data. If data were graphed and objectives were indicated on the graph, it would be easy for all to see what progress was being made toward meeting those objectives. It would also be readily apparent if data were not being collected to monitor an objective.

# APPENDICES

# Appendix A: Scope of Work

# SCOPE OF WORK FOR CHILD SURVIVAL IX - MALAWI
# FINAL EVALUATION

## I. INTRODUCTION

This is a scope of work for the Mid-term Evaluation of ADRA's USAID funded Child Survival IX project which was signed on September 27, 1993 by Mario Ochoa, Executive Vice President of the Adventist Development and Relief Agency. The project was designed to have a three year life beginning on or about September 30, 1993 and ending September 29, 1996.

To fulfill the evaluation requirements outlined in the cooperative agreement, a Mid-term Evaluation was carried out in March of 1995. ADRA also submitted two annual reports. These documents summarize project inputs and outputs, progress to date, barriers to success, and project highlights.

According to the agreement the Final Evaluation Report must be completed prior to the grant expiration date and be included in ADRA's Child Survival IX Final Report to be submitted to USAID before November 30, 1996.

## II. THE PURPOSE OF FINAL EVALUATION

The prime purpose of the Final Evaluation for Child Survival Projects is to address three crucial issues. These are: effectiveness, sustainability and lessons learned.

In the area of effectiveness the Final Evaluation looks at the extent to which the Child Survival activities met the basic health needs of the recipient communities as stated in the goals and objectives of the project.

Likewise, the Final Evaluation assesses the project's competence and prospects in terms of carrying out sustainable and effective Child Survival activities.

Ultimately, the Final Evaluation shows what lessons, if any, positive and/or negative, intended and/or unintended, are learned. It is expected that such lessons will benefit ADRA/I's own current and future Child Survival projects around the world. Furthermore, if and when applicable, the gained knowledge will be disseminated to all other organizations who deal with Child Survival Projects.

## III. GOALS AND OBJECTIVES

The goal of Malawi's Child Survival IX Project is to decrease morbidity mortality and improve the quality of life for low income mothers and children in the north half of Nsanje District, the southern most district in Malawi.

At the heart of ADRA's strategy is the mother as the primary care giver. As such the majority of activities will be educational and promotional in nature. This involves educating and motivating mothers to improve their health practices and encouraging them to increase the utilization of the existing, but enhanced, community services.

***The project objectives include:***

**Nutrition**

1. 80% of WCBA (15,332) will have received instruction regarding nutrition during infancy, and childhood.

2. High Baseline levels of appropriate infant feeding practices have been maintained. 40% of mothers with infants less than four months (667) are practicing exclusive breastfeeding.

3. 60% of WCBA (11,499) will increase their food intake during pregnancy.

4. 80% of pregnant/lactating women (4,412) will receive a single dose of Vitamin A within four weeks of delivery and 80% of 6-72 months (19,238) will receive a maintenance dose of Vitamin A every six months. 50% of households with WCBA (5,000 households) will have a vegetable garden.

**AIDS prevention**

1. 100% of HSAs (20) and volunteers (450) have received training in HIV/AIDS prevention and counseling.

2. 80% of VHC's (130) have been trained in HIV/AIDS prevention in the community.

3. 90% of target population age 1545 knows HIV/AIDS high risk behaviors and appropriate preventive behaviors.

4. 20% of target population age 1545 report having sex with only one partner.

**Growth monitoring**

1. 80% of O-l 1 month old children (4,004) will participate in a monthly growth monitoring program.

2. 50 % of 12-23 month old children (2,3 15) will participate in a growth monitoring program every three months.

**Family planning**

1. 80% of the VHCs (130) will have received instruction regarding the importance of and methods of family planning.

2. 100% of volunteers (450) trained in Family Planning counseling.

3. 25 % of those desiring no more children are using a modem method of birth spacing.

**CDD**

1. 80% of O-23 month old children (7,708) in both remote and non-remote areas will receive appropriate home management in diarrheal episodes including increased fluids, increased feeding, and appropriate care seeking

**EPI**

1. 85% of children 12-23 months of age (3,936) in both remote and non-remote areas will have been fully immunized.

2. 60% of WCBA (11,499) have received at least two TT doses.

**LITERACY (Adjunct fund)**

1. 2000 WCBA have completed the basic functional literacy course

## *Indicators for sustainability*

According to the DIP development activities planned are not based on cash or other inputs, therefore, continued financial support will not be necessary at the end of the project. The following are the measurable objectives and indicators.

1. Volunteer activity has been institutionalized in the community.

2. Volunteer referrals are accepted by HC/HP staff.

3. Quality monitoring system is regularized at HC/HP.

4. Comrnunity level system of women's groups, VHCs, HSAs, and HPs/Mobile clinics capable of addressing other and new community health problems.

5. Following activities continue in the community, reinforced and taught through mothers' groups, and VHCs:

+ CDD home management and referral for moderate/severe dehydration
+ EPI promotion
+ HIV/AIDS prevention education
+ FP promotion
+ GM Nutrition, weighing and nutrition messages
+ Vit A distribution
+ Vit A and iron rich vegetable garden promotion, technical help and seed supply.

6. For the summaries of the indicators to be monitored, refer to the attached tables at end of the Scope of Work.

### *The DIP's measurable objectives and indicators for sustainability*

The measurable objectives and indicators of the project to track sustainability are: *1) Programmatic objective:* Continuation of child survival service delivery in the project area as measured by the number of services delivered each year. *2) Institutional objective: The* PCH clinic and the SMH will continue to exist and provide services at the end of the project. The indicator is the presence of the clinic and hospital at Kavre at the end of the project. *3) Financial objective:* Part of the costs of the PHC clinic will be covered by fees collected. The indicator will be the existence of the operational fee structure.

**Specific objectives**

1. CHV activity has been institutionalized in the community

2. TBA's are accepted as the preferred maternal care provider by the community

3. Referral system is institutionalized in MOH system

4. HIS system is institutionalized in DHO

5. Following activities continue in the community - reinforced & taught through mothers groups:

+ CDD home management an referral for moderate/severe dehydration
+ ALRI recognition, appropriate referral/ treatment
+ MC ante natal care and safe delivery practices
+ NUT appropriate weaning foods and during pregnancy and lactation

6. Continued operation of Banepa Primary Health Care Clinic has been assumed by local

organization (Municipality or DHO)

7. Community level system of women's groups, CHV's, TBA's ward members, VHW's and MOH referral system capable of addressing other and new community health problems.

8. Community level system of women's groups, CHV's, TBA's ward members, VHW's and MOH referral system capable of addressing other and new community health problems.

### *Utilization Of Previous Documents For the Final Evaluation*

The goals and objectives (including planned inputs and expected outputs) of Malawi's Child Survival IX Project must be viewed in the light of the suggestions and recommendations that were made at the end of the Mid-term Evaluation which took place at the half life of the project - March 1995. Moreover, the evaluation team needs to familiarize itself with the previous two annual reports that were submitted to USAID. These documents should help the evaluation team understand the strengths and weaknesses of the project until the time of their respective publications and provide direction for the remainder of the project's life.

## *Iv.* EVALUATION METHODS

### A. Evaluation Concept

It is helpful to remember that the process of evaluation is never far from its social setting. In view of this, the evaluation team may realize that no matter how objectively the data was gathered and analyzed, in the end, the final interpretation can not totally be free of the social and political climate of the time and the personal biases of the evaluator. Therefore, the evaluating team is expected to be unduly astute with its written presentation as this involves the lives of many whose welfare could be affected either positively or negatively. The team may keep in mind that we are social beings and as such, every assessment we do apparently takes place in a cultural context. Consequently, there are ideas that do not make sense outside their social milieu.

This evaluation takes place in the context of two cultures, that of the funder's culture and that of the beneficiary's culture. The evaluation team should keep in mind that it is undertaking a major responsibility in its attempt to make a cross-cultural analysis and interpretations.

### B. Evaluation Guidelines:

The evaluation process will focus on the guidelines designed by USAID for the Final Evaluations of all USAID funded Child Survival Projects and the supplementary questions. The evaluation team is

reminded that all USAID funded Child Survival Projects are required to respond to the sustainability questions and issues outlined in the Child Survival Guidelines.

It goes without saying that every country is unique and Malawi is not an exception. In the event that there may be questions which do not apply. Please, do not manipulate the questions to manufacture its applicability, but explain why the question does not apply.

It is obvious that a beneficial evaluation is a result of reliable data collection. Collection methods may include: general observations, surveys, interviewing recipients and/or staff, gathering information from written material, and so on.

In the preparation of the final report, the evaluating team is requested to provide the reader with, as much as possible, accurate sources of its information and conclusions. In fact, all evaluation statements must be backed by existing data. When this is not the case, the team is required to state this fact and provide a rationale for its observations and conclusions.

### C. Evaluation Activities

Following these guidelines and taking the program objectives and the measurable objectives and indicators for sustainability as listed above, the evaluation team is expected to perform the following.

First, the evaluation team must answer the question of the project's effectiveness. In other words, to what extent did this Child Survival Project meet the basic health needs of the recipient communities as stated in the goals and objectives of the project.

Second, the evaluation team must assess the project's competence and prospects in terms of carrying out sustainable and effective Child Survival activities.

Ultimately, the Final Evaluation has to show what lessons, if any, positive and/or negative, intended and/or unintended, are learned that may help others in operating diverse Child Survival Projects.

## V. ETHICAL, CONCERNS AND FREEDOM OF INFORMATION

It is ADRA's position that when evaluating and/or studying any form of human behavior, ethical concerns are paramount. Thus, ADRA/I accepts the ultimate responsibility for gathering and disseminating information from all of its regional offices around the world. Consequently, ADRA/I requires the evaluation team particularly the hired consultants, to turn to ADRA/I all the data and other information which were used as the basis of the team's Final inferences.

It is ADRA's position that no evaluation is final until it is presented to ADRAA,
discussed with the consultants in an open manner, clear understandings of all conclusions and any differing views are reached between the consultant and ADRAA as reflected in the final document.

ADRA/I considers it unethical for any member of the evaluation team to use information gathered during the evaluation assignment for anything other than the evaluation under study. Should viable reason present itself for using the information obtained for other purposes, then, ADRA/I must be consulted and prior permission secured. This must be adhered to, especially when the material is of a controversial nature and exclusively involves the private lives of individuals in a given community and/or ADRA's internal affairs.

## VI. COMPOSITION OF THE EVALUATION TEAM

The evaluation team will consist of Dr. Lester N. Wright (Independent Consultant), Solomon Wako (ADRA Headquarter Representative), Max Church (ADRA/Malawi Country Director), Mr. Katumbe (Malawi Child Survival Project Director), one MOH Representative, possibly one USAID Representative.

## VII. CALENDAR OF EVALUATION ACTMTIES - 1996

Dr. Wright arrive's ADRA/Malawi ..... August 3
Meet with evaluation team ..... August 4
Field Visit (Focus Croup, Mothers and Community Leaders) ..... August 5-9
Off ..... August10
Field Visit ..... August 11-14
Debriefing (MOH, District Health office, Union Mission Head office) ..... August 15-l 6
Departure ..... August 17
Report Writing ..... August 18-23

## VIII. REPORT FORMAT

The Final Evaluation Document will be written using the following outline:

1. Title Page. The title page will state the name and project number, names and titles of consultants, and date and name of the document.
2. List of Acronyms. Unusual or obscure acronyms should be identified at the beginning of the report.
3. Executive Summary. The executive summary synthesis should be no more than five pages in length and will include: background of project, evaluation methodology, accomplishments and impact of the project, concerns and recommendations:
4. Table of Contents. The table of contents should outline each major topic section, appendices, figures, maps, tables, etc.
5. Body of the Evaluation. The body of the evaluation report will include the following in sequential order:
   - *Introduction and background:*
     The introduction and background will include at a minimum: Justification for awarding grant, goals and objectives of the grant, chronological order of

project implementation and, the purpose of the evaluation.

- *Evaluation Methodology:*
  The evaluation methodology will include at a minimum: description of data collection and evaluation sites selection processes.
- *Sustainability Issues:*
  The section on sustainability issues will include sequential responses to the sustainability questions and issues outlined in the **Child** Survival Final Evaluation Guidelines.
- *Supplementary Issues and Questions:*
  This section will address in sequence the supplementary issues and questions outlined in this Scope of Work.

6. Appendices. The appendices included will be at the discretion of the evaluation team. However, the appendices must include the scope of work, itinerary for the evaluation visit, list of individuals interviewed/surveyed during the evaluation, surveys and interviewer questionnaires, references cited, and maps. Additional appendices such as case studies, etc. may be included as determined appropriate by the evaluation team.

## *Ix.* BUDGET FOR EVALUATION

The budget for the Final Evaluation of ADRA/Malawi's Child Survival IX Final Evaluation is attached.

The table below summarizes the indicators to be monitored, how and when.

| Indicators/Data | Method of Collection | When Collected |
|---|---|---|
| Family Planning Effect Indicators: | | |
| 1. Percent of mothers of children less than 24 months of age who desire no more children in the next two years, or are not sure, who are using a modern contraceptive method. | 1. Survey | 1. Baseline, EOP |
| Family Planning Output Indicators: | | |
| 1. Percent of VHCs trained in family planning.<br>2. Percent of volunteers trained in family planning counseling.<br>3. Percent of WCBA living within 5 km of family planning commodity service provider.<br>4. 163 VHCs trained.<br>5.52 HSAs trained. | 1. Training Report<br>2. Training Report<br>3. Survey<br>4. Training Report<br>5. Training Report | 1.<br>2.<br>3. Baseline. EOP<br>4.<br>5. |
| 6. 450 volunteers u-dined.<br>7. At least one key message monthly in 163 villages; 163 community FP promotional events at least quarterly.<br>B. 450 vol's reviewed monthly by HSAs. | 6. Training Report<br>7. Monthly/Quarterly Report<br>8. Monthly Supervision Report | 3.<br>4. Monthly, Qmly<br>5. Monthly |
| 9. One home visit to each high risk woman (15-19, 35-44=9,940) at least quarterly for FP promotion.<br>10. Consistent supply at HCs/HPs.<br>11. Increased accessibility of FP supplies into 163 villages through CBD. | 9. Monthly Report<br>10. Qrtrly stock inventory checks<br>11. Survey, Quarterly Reports, FP Delivery Site list | 6. Monthly<br>7. Quarterly<br>8. Quarterly |
| Nuaition- Effect Indicators: | | |
| 1. Percent of mothers knowing correct time to introduce solid/semisolid foods. | 1. Survey | 1. Baseline, EOP |
| 2. Percent of mothers knowing which focds contain Vitamin A. | 2. Survey | 2. Baseline, EOP |
| 3. Percent of mothers indicating they ate same or more than usual during last pregnancy. | 3. Survey | 3. Baseline, EOP |
| 4. Percent of infants/children (under 24 months) who were breastfed within the first eight hours after birth. | 4. Survey | 4. Baseline, EOP |
| 5. Percent of infants less than four months, who are being given only breastmilk. | 5. Survey | 5. Baseline, EOP |
| 6. Percent of infants between five and nine months, who are being given solid or semi-solid foods. | 6. Survey | 6. Baseline, EOP |
| 7. Percent of children between 20 and 24 months, who are still breastfeeding (and being given solid/semi-solid foods). | 7. Survey | 7. Baseline, EOP |
| 8. Percent of mothers stating that they ate more food than usual during pregnancy.<br>9. Number of pregnant/lactating women receiving single dose of Vitamin A within four weeks of delivery and children under six years receiving Vitamin A dose in past six months.<br>10. Number of households growing Vitamin A and iron rich vegetables during the normal growing season. | 8. Training & Monthly Reports<br>9. Survey<br>10. Monthly Report, Survey | 8. Monthly<br>9. Baseline. EOP<br>10. Monthly, Baseline, EOP |
| Nutrition Output Indicators: | | |
| 1. 52 trained HSAs, quarterly refresher training.<br>2. 450 vol's and 163 VHCs trained.<br>3. Monthly weighing of O-l 1 month olds at 22 HC/HP/Mobile clinics and eight remote communities.<br>4. Key message communication events at: 22 monthly weighing clinics, eight CB weighing clinics, 450 monthly women's group meetings.<br>5. At least monthly home visits to 4000 at risk households (est. 40% of households).<br>6. Home visits to est. 467 LBW infants annually. | 1. Training Report<br>2. Training Report<br>3. Number clinics assisted monthly<br>4. Monthly Report<br>5. Monthly Report<br>6. Monthly Report | 1.<br>2.<br>3.<br>4. Monthly<br>5. Monthly<br>6. Monthly |
| 7. Key message communication strategy specifically designed to overcome local beliefs on early introduction of solid/semisolid foods. | 7. Satisfaction. KABP Survey | 7. |
| 8.52 HSAs trained, quarterly refresher training.<br>9. 450 vol's trained.<br>10. 19.238 (86%) of children 6-72 months and 4,412 (80%) pregnant/lactating women receive appropriate annual Vitamin A dose(s) through 30 monthly weighing clinics or six monthly campaigns. | 8. Training Report<br>9. Training Report<br>10. Clinic Records, six Monthly Census Check | 8.<br>9.<br>10. |

| | | |
|---|---|---|
| 11. 52 HSAs trained, quarterly refresher training.<br>12.450 vol's trained in garden promotion.<br>13.150 families growing model gardens assisted by ADD technical assistance and seeds.<br>14.50 families growing model gardens from ADRAAEF technical assistance in remote areas.<br>15. Number of key message communfcation events by volunteers. | 11. Training Report<br>12. Training Report<br>13. Monthly Report<br>14. Monthly Report<br>15. Monthly Report | 11.<br>12.<br>13. Monthly<br>14. Monthly<br>15. Monthly |
| **Growth Monitorin Effect Indicators:** | | |
| 1. Percent of 0-11 month old children weighed in Past month.<br>2. Number of vohmteers following up high risk households with home visits. | 1. Monthly Report, Survey<br>2. Monthly Report | 1. Monthly, Baseline, EOP<br>2. Monthly |
| 3. Percent of 12-23 month old children weighed in past three months. | 3. Survey | 3. Baseline, EOP |
| **Growth Monitoring Output Indicators:** | | |
| 1.52 HSAs trained.<br>2. 450 vol's trained.<br>3. 22 monthly weighing clinics.<br>4. Eight community based weighing sights weighing 4,004 (80%) of 0-1 1 months and 2,315 (50%) of 12-23 months.<br>5. Home visits to high risk households by volunteers.<br>6. Number of volunteers following up high risk households with home visits.<br>7. High risk follow-up in nutrition clinics/clubs, rehab units. | 1. Training Report<br>2. Training Report<br>3. No. Clinics, Monthly Report<br>4. No. Clinics, Monthly Report<br>5. Monthly Report<br>6. Monthly Report<br>7. Clinic Records | 1.<br>2.<br>3. Monthly<br>4. Monthly<br>5. Monthly<br>6. Monthly<br>7. |
| **EPI Effect Indicators:** | | |
| 1. Percent of children 12-23 months who received DPTl .<br>2. Percent of children 12-23 months who received OPV3.<br>3. Percent of children 12-23 months who received measles vaccine.<br>4. Percent change between DPTl & DPT3 doses [(DPT1-DPT3)/DPT1]x100 in children 12-23 months.<br>5. Percent of mothers who received two doses of tetanus toxoid vaccine before the bii of their youngest child less than 24 months of age. | 1. Survey<br>2. Survey<br>3. Survey<br>4. Survey<br>5. Survey | 1. Baseline, EOP<br>2. Baseline, EOP<br>3. Baseline, EOP<br>4. Baseline. EOP<br>5. Baseline, EOP |
| **EPI Output Indicators:** | | |
| 1.52 HSAs retrained.<br>2. 450 vol's retrained.<br>3. At least 163 communication events monthly in community groups and 30 EPI/GM clinics.<br>4. Supervision of mobile clinic for accessibility coverage.<br>5. Home visits to high risk.<br>6. Monthly reporting of measles cases to VHC, HC. | 1. Training Report<br>2. Training Repot-t<br>3. Monthly Repot-t<br>4. Quarterly Supervision Report<br>5. Monthly Report<br>6. Monthly Report | 1.<br>2.<br>3. Monthly<br>4. Quarterly<br>5. Monthly<br>6. Monthly |
| 7. Supplies in use.<br>8. Cold chain monitoring verified. | 7. Observation, Quarterly Supervision Report<br>8. Observation, Quarterly Supervision Report | 7. Quarterly<br>8. Quarterly |
| **AIDS Prevention Effect Indicators:** | | |
| 1. Conmnmities knowledgeable and increasingly practicing HIV/AIDS preventive behaviors. | 1. Survey | 1. Baseline. EOP |
| 2. Percent of target population age 15-45 correctly identifying high risk behaviors and appropriate preventive behaviors. | 2. Survey | 2. Baseline, EOP |
| **AIDS Prevention Output Indicators:** | | |
| 1. At least quarterly focus group discussions with 163 VHCs and elders groups. | 1. Quarterly Report | 1. Quarterly |
| 2. 10 drama teams giving at least one presentation to 130 (80%) villages at least quarterly.<br>3. HSAs trained.<br>4. 450 vol's, 163 VHCs trained.<br>5. Key message events in 130 (80%) villages at least quarterly. | 2. AIDS IEC Events Report<br>3. Training Report<br>4. Training Report<br>5. AID IEC Events Report | 2. Monthly<br>3.<br>4.<br>5. Monthly |
| 6. Increase in numbers of testing sites offering HIV testing for Public in project area (presently 0).<br>7. Percent of HSAs and volunteers receiving training in HIV/AIDS prevention and counseling.<br>8. Percent of VHCs receiving training.<br>9. Percent of target population age 1545 reporting sex with only one partner. | 6. Hospital/HC/HP Reports<br>7. Quarterly Training Report<br>8. Quarterly Training Report<br>9. Survey | 6. Monthly<br>7. Quarterly<br>8. Quarterly<br>9. Baseline, EOP |
| CDD Effect Indicators: | | |

| | | |
|---|---|---|
| 1. Percent of **infants/children (under** 24 months) with dianhea in the past two weeks who were given the same amount or more **breastmilk.**<br>2. Percent of infants/children **(less** than 24 months) with dianhea in the past two weeks who were given the same amount or more fluids other than **breastmilk.**<br>3. Percent of infants/children (less than 24 months) with diarrhea in the past two weeks who were given **the** same amount or more food.<br>4. Percent of infants/children (less than 24 months) with diarrhea in the past two weeks who were treated with ORT. | 1. Survey<br>2. Survey<br>3. **Survey**<br>4. Survey | 1. Baseline, **EOP**<br>2. **Baseline,** EOP<br>3. Baseline, EOP<br>4. Baseline. EOP |
| **CDD Output Indicators:** | | |
| 1.52 **HSAs** retrained.<br>2. 450 vol's **retrained.**<br>3. At least one key message event monthly in 163 villages.<br>4. Home visits to high risk families.<br>5. **Staff** of 10 **HCs/HPs** perform at least quarterly self evaluation supervision reports, using commonly agreed on checklists.<br>6. Distribution in selected villages. **particularly** during rainy season.<br>7. Increase households with pit latrines from EOP CS **IV** of 43 % to 65 % .<br>**8. Experimental sand/gravel/charcoal home water filters pilot tested in 100 households.** | 1.TrainingRepot-t<br>2. Training Report<br>3. Monthly Report<br>4. Monthly Report<br>5. Quarterly Supervision Report<br>6. Distribution Log, Inventory Records<br>7. Observation, Survey<br>8. Observation | 1.<br>2.<br>3. Monthly<br>4. Monthly<br>**5. Quarterly**<br>**6.**<br>7:<br>8. |
| **Literacy (Adjunct fund) Effect Indicators: None** | | |
| **Literacy (Adjunct fund) Output Indicators:** | | |
| 1. GOM curriculum.<br>2. Health messages included in curricuhun.<br>3. 10 literacy teachers trained.<br>4. Teaching supplies in use.<br>**5. 2,000** literacy grads also exposed to CS key messages.<br>6. Number of WCBA completing the basic functional literacy course. | Quarterly Reports, Post Test, **Evaluated** through other intervention evaluation methods (effectiveness of key message communication) | |

| Project Objectives by Intervention | Measurement Method How/When (Effect indicators and SOURCE) | Major Planned Inputs and Activities | Outputs | Measurement Method & Data SOURCE - How/When |
|---|---|---|---|---|
| MANAGEMENT, MOH SYSTEMS & LOCAL COMMUNITY SYSTEMS **STRENGTHENING** | | | | |
| Staff have been involved in developing, understand and are monitored by project work plans. | Staff job descriptions.<br>Quarterly work plans.<br>Annual work plan.<br>Signed quarterly staff reviews of work plans by position. | 1. Staff participate in baseline, DIP preparation.<br>2. Quarterly work plans developed for each position.<br>3. Quarterly work plans reviewed at end of period with each staff member. | + More efficient usage of time | + Staff evaluations, and interview - QRTRLY STAFF EVALUATIONS, MTE. EOP |
| There is general participation in & satisfaction with vol by community members. | VHC meets monthly.<br>VHC has regularly promoted vol's in community.<br>Vol shares monthly report with VHC.<br>Community members evidence satisfaction with vol.<br>FOCUS INTERVIEWS. MTE, EOP. Vol MONTHLY REPORT | 1. VHC regularly promotes vol's in community.<br>2. VoI shares monthly report with VHC.<br>3. HSA meets Qrtrly with **VHCs**.<br>4. VHC discusses monthly report with HP/HC. | + Enhanced status of Vol in conlnlunity<br>+ Satisfaction of community with vol | + FOCUS INTERVIEWS OF MOTHERS, MTE, EOP |
| MOH is utilizing a service quality monitoring system for services related to project interventions. | Quarterly service quality supervisory visits<br>**HC/HP** - Severe diarrhea management, EPI, FP.<br>QUARTERLY SERVICE QUALITY SUPERVISORY VISIT RECORDS, MTE & EOP SURVEY | 1. Service quality checklists developed as self evaluation instrument with **HSAs** and HClHP staff.<br>2. Supervisory visits of **HC/HP** staff at least qrtrly. | + Improved service quality by HClHP | + See **column** 2 |
| HSA, **HC/HP** staff have been given refresher training in specific interventions. | PRETEST, POSTEST.<br>SUPERVISORY FOLLOW-UP VISITS USING CHECKLISTS | 1. Refresher training for existing **HC/HP** staff. | + Trained **HSA's,** HCNP staff giving quality services<br>4 Health Centers<br>***4 Health Posts*** | + See column 2 |
| ADRA staff are participating in regular professional upgrading activities. | QRTRLY REPORTS | 1. Monthly staff meetingslinservice.<br>2. Qrtrly review sessions with staff and refresher training for **HSAs**.<br>3. Proj Manager-2 annual conf's.<br>4. **Annual** CSSP regional conf for lead staff.<br>5. Local agency's workshops for lead **staff at least 2x yrly**. | + Improvement of professional **skills** of ADRA staff<br>+ Project management skills of lead staff upgraded | QRTRLY REPORTS, STAFF EVALUATIONS |

# Appendix B: Evaluation Team

Lester N. Wright, MD, MPH, Consultant
Associate Commissioner/Chief Medical Officer
New York State Department of Correctional Services
Albany, New York

Martha Bokosi
Family Health Officer
Southern Regional Health Offrce
Blantyre

Max Church
ADRA/Malawi Country Director
Blantyre

Kristine M. Gebbie, RN, DrPH
Elizabeth Standish Gill Assistant Professor of Nursing
Columbia University School of Nursing
New York, New York

Percival Katurnbi
Project Manager
ADRA Child Survival IX
Ngabu

Geofiey Makhilira
District Environmental Health Officer's Representative
Nsanje District Health Offrce
Nsanje

Richard M'manga
Family Planning and STD Coordinator
International Eye Foundation
Nchalo

Solomon Wako, PhD
Director of Evaluation
ADRA/International
Silver Spring, Maryland

# Appendix C: Itinerary for the Evaluation Visit

## 1. Schedule of Evaluation

Sunday, 5 August 1996:

Evaluation Team Organization Meeting at Ngabu

Monday, 6 August 1996:

Nsanje District Office of Health

Kalemba Parish Clinic

Health Centers/Health Posts
- Phokera
- Sorgin
- Tengani

Tuesday, 7 August 1996:

Health Centers/Health Posts
- Masenjere
- Mlolo

Villages
- Buleya
- Chipolopolo
- Dogo
- Ntolongo
- Ntondo

Wednesday, 8 August 1996:

Health Centers/Health Posts
- Nchacha

Villages
- Chaunk
- Kampira
- Khavala
- Makhapa
- Mathenga

Ntchenyera

Thursday 8 August 1996:

Health Centers/Health Posts
Sankhulani

Villages
Aironi
Masamba
Mne'mbe

Friday, 9 August 1996:

Health Centers/Health Posts
Kanyimbi
Makhanga
Misamvu

Villages
Kamanga
Nkolimbo
Osiyana

Sunday 11 August through Wednesday 14 August 1996:

Writing report

Wednesday 14 August 1996:

Malawi Union of Seventh-day Adventists

Thursday 15 August 1996:

USAID, Malawi Mission, Lilongwe

## 2. Field Observations of Evaluation Team

The area served by CS IX is the northern portion of the southernmost area of Malawi, the Nsanje District. As described in the introduction to this project, the area has the highest rate of infant mortality in the country, and a very low level of available services. While it has benefited from policies of the current government such as the opening of free primary education for all children, it has limited transportation and communication systems, and a limited economic base. Discussions with health staff revealed difficulties recruiting to fill available positions, and at least

one individual stated that some perceived being assigned to Nsanje as a form of punishment for those out of favor with higher-ups. This same hospital matron made what may be one of the most important observations gathered, "Nsanje isn't difficult; Nsanje has been neglected."

As detailed in Appendices C and D, the evaluation team spent five days in the Lower Shire Valley visiting villages, health centers, health posts and hospitals serving the target population. In conversations lasting from 15 minutes to over an hour, individuals and groups shared their perceptions of the health of mothers and children, of CS IX, and of how present experiences differ from those of three years ago. As a rough summary, it can be stated that ADRA's efforts are widely known at the community level, and are understood to have had a positive influence on health status. It also became clear that the level of need was so high that improvements have only scratched the surface and served to whet people's appetites for what might be possible. It is unclear that the communities and Ministry of Health, even working together as planned, will be able to respond adequately in the intermediate future.

Villages

First encounters with villages ranged from singing and dancing as the vehicle bounced to a stop near the meeting place to a long period of quiet as efforts were made to locate the headman, VHC, VHV and others expected to take part in the event. Part of this variation is due to communication difficulties: HSAs were only able to let volunteers know which day the visit was scheduled, and an approximate time. Especially during busy morning hours, women were reluctant to let all chores wait indefinitely for unknown visitors and often had to be gathered from home, field or borehole once it was time for the discussion to begin.

At the first stop of each day, the HSA and village volunteers had arranged for presentation of a "drama", a locally scripted presentation of a health education message from the CS IX project. Casts ranged from 5 to a dozen or more, and lessons portrayed included EBF, HIV prevention, AIDS home care, vegetable gardening and food preparation, treatment of diarrheal diseases, and growth monitoring. In addition to clear depiction of healthy choices, traditional practices were challenged, often with humor. Grandmothers, traditional healers, traditional birth attendants and even a village headman (played by himself) were questioned, or did part of the questioning. In what may have been the most direct challenge to traditional roles, two young mothers playing the part of men in a presentation on the spread of HIV were dressed in trousers, caps, sunglasses and neckties, and remained in costume for the duration of the visit. In each case, the audience grew during the presentation; the slowest to join were men (other than health committee members) who stayed well to the sides and back, but appeared to be listening closely.

Following this clear evidence of CS IX health education in action, discussion focused on the practical aspects of health and illness in the village, on what had been learned or experienced during the project and on what might be done next. In some cases this discussion was held with the group as a whole; often evaluation team members met separately or in some smaller subgroups with the headman, the VHC, the VHV, the HSA serving that community, the women

of the community and the men of the community. This same pattern was followed in those sites where no drama was presented.

Health problems being encountered include malaria (at one location, 5 infants had died of this disease in March), diarrheal diseases, measles (an outbreak among older children, many of whom had received vaccine years before as infants, was occurring in part of the district during the evaluation), malnutrition, eye problems. The most commonly reported area of success was sanitation, including use of pit latrines and sand plats, maintenance of the boreholes and surroundings, and personal habits. This behavior change was not a specific objective of CS IX, but could contribute to reduction of diarrheal diseases and general improvement in health status. Other reported successes include increased use of vegetables from home gardens, increased interest in Under-5 clinics (with corresponding increases in level of immunization), higher rates of EBF, better management of diarrheal episodes when they occur, and interest in family planning (at least on the part of women). As described in one village "the children still get sick, but they are stronger now and they recover instead of dying." Without prompting, HIV/AIDS was rarely mentioned; requests for additional boreholes were almost universal.

Vegetable gardening was common and popular, though not all families had incorporated some of the new produce into family eating. Preparation of vegetables was a focus of home craft workers where available. In a number of cases, crops were sufficient to generate some income by marketing the amount beyond family need. Few volunteers had apparently clarified that ADRA would no longer be distributing seeds; work will be needed so that funds for purchase are set aside by families or villages (seeds are readily available in markets). A challenge for gardens in villages away from the river bank is the need to water cattle; "vegetables lose out to the cows," according to one VHV.

While it was possible to elicit some reported improvement in health status from almost every community, there were many in which the changes were slight. One village maintained that they had heard nothing of the project and seen no change; in another, a large number of children appeared to have current, acute problems including intestinal parasites, eye infection, fever and malnutrition. At locations where the reported change was small, evaluators heard that people listened to messages but didn't want to change; that village leadership was only slightly interested; that grandmothers and other elders dismissed the new messages as being of little value. From many sources came the need to better involve the men. This was specifically attached to concerns about the rate of contraceptive use. Wives who became interested in family planning were discouraged by their partners (though Malawian law allows them to receive contraception at their own request). Reports fi-om health centers and health posts, however, indicate a relatively steep rate of increase in requests for these services despite the masculine discouragement. The leadership of some (male and female) village health committee members willing to discuss their own contraceptive practices is expected to have a positive impact.

In probing about AIDS, it became clear that AIDS awareness and prevention messages have made only a small impact in most of these communities. Despite clear indications otherwise from MOH and PVO staff, villages reported no or very few cases of disease. One

HSA's description was of AIDS as a "halfway serious problem here". In the more isolated and conservative communities, traditional practices such as sexual cleansing of a woman following her husband's death (in which she is expected to engage in unprotected intercourse with a man hired by the community but unidentified to her) continues with little interest in change. By way of contrast, the practice has been virtually eliminated in some places, having been replaced by cleansing rituals involving herbs or chicken blood. Involvement of religious leaders from all faiths, including traditional religious leaders, in the HIV training for volunteers and village health committees may be a very important step in accelerating HIV prevention. It was reported from several communities that religious leaders are taking advantage of funeral gatherings to ask health volunteers to give short health messages to the gathered group.

Though this project did not focus on clean water, and did not drill boreholes, it is clear that the communities associate (appropriately) getting a convenient source of non-salty water as an extremely useful early step in changing health practices. Likewise, expansion of the number of pit latrines in public gathering places as well as adjacent to individual dwellings is understood to have an important role in control of diarrheal and other diseases. Based on community comments from all across the district, continuation of efforts in these areas by ADRA, other PVOs and MOH will be an important message to the communities that the community organization supported by this project will be taken seriously and external groups will respond appropriately with assistance.

The U5 clinics not only provided a good opportunity to monitor growth of children, increase immunization rates and reenforce good health practices, they provide an occasion for mothers to gather and share. This is a luxury of time apart from specific tasks that is relatively rare, according to some reports. This increased interaction also stimulated interest in other possibilities for development, such as the request for a kindergarten in one village, and regular suggestions that adult literacy classes for women would be well-received. The good response to U5 clinics appeared to be the case whether the clinic was held at a fixed site, such as a health clinic or health post, or was a mobile clinic. VHV from the villages regularly assist with many of these clinics, which assures continuity for follow up or referrals.

Village Leaders and Volunteers

The involvement of the village headman may have been the single most important factor in the level of success of CS IX in any one village. Where the headman attended training with VHVs and VHC members, or even actively served on the VHC himself, there was no question of continuing a village interest in health. The consistent message across all villages was that health had to be their concern, no matter what any outside groups did about it, "What we have learnt is beneficial and we shall continue." VHC members generally stated that they would continue their efforts, even if they were no longer receiving training by ADRA. Some HSAs suggested that incentives offered by ADRA (occasional bars of soap, for example) were responsible for this level of interest, and that absent the incentives, interest would wane. This observation was more common on the west side of the Shire River where greater concentrations of refugees from Mozambique had lived with a resultant larger presence of outside support by NGOs. More

commonly the expectation was that there would be some complaining that the MOH did not offer training as frequently or incentives other than training allowances, and some gradual falling away of committee members, but that the overall effort would go on. VHC members in more active communities accepted responsibility for identification and training of replacement members over time.

Likewise, most of the VI-IV stated an expectation of continued work under the more general supervision of the MOH. They appear to enjoy the challenges of their work, and take pride in the positive changes identified. They see themselves as role models as well as teachers, e.g. in use of contraceptives. There was no reported formal mechanism for the development of replacement volunteers, either to fill the slots of those who have already become inactive, or to deal with normal attrition. Likewise, the involvement of volunteers in U5 clinics, local immunization campaigns or other special activities seemed to be more happenstance than built into the district structure. It was unclear how PVOs working in the same community coordinated approaches to volunteer incentives. Some of the volunteers have also been able to secure through ADRA small quantities of medications or other supplies for use in their villages; no replacement sources have been identified, nor has this been made area-wide.

As a measure of continuing interest, VHV and VHC members in one community had two requests as this particular project phases out. The first was that they receive some type of recognition or acknowledgment of their efforts to date: a certificate, a ceremony, or some other signal that they had made a difference. The second was that they be remembered, so that the next project coming into their village would start with them and what had been done to date, rather than begin as if nothing had gone before.

HSAs and MOH

The Health Surveillance Assistant is the most important communication link in the approach used by ADRA for CS IX. These individuals carry health messages to communities, coach and support both VHVs and VHCs and are the compilers of health status and health service information from the village level. While hearing about a range of skill, the general report was a positive one: these people have made a difference to the community. Because HSAs have been employed by MOH as well as ADRA, some comparisons were made. In general, ADRA HSAs were seen as having excellent work habits, being punctual, reliable, consistent in their efforts. This may be related to the intensive level of supervision they received from CS IX; monthly training meetings have not been the norm for MOH HSAs. The reported weakness of the ADRA project HSAs was that of limited scope of knowledge, as contrasted with the typical MOH staff This may be because CS IX based specialists in specific parts of the service area, and the HSAs closest to each specialist had an opportunity to learn that one subject very well. Given the general responsibilities of HSAs, this is a definite weakness if the advanced information in one area is not built on a sound general health base.

The transfer of ongoing supervision to the MOH is of concern to staff at Health Centers and Health Posts as well as VHV and others at the village level. The MOH is understood to be

operating under a very constrained budget and to have fewer resources for the supervision and training of HSAs which could mean deterioration in the level of effort. There were conflicting reports about the degree to which the phasing out of CS IX was anticipated. The already-completed transfer of some HSAs to MOH payroll is very positive, as is the approval the District Health Office reports for hiring of many more HSAs. This word has not been fully communicated to the village level as of yet, however.

There are other practical concerns. The CS IX project has been doing maintenance of all bicycles used in village health promotion, regardless of who owns/uses those cycles. Given distances and the state of roads, functioning bikes are essential for maintaining communication, and the MOH, though it has recently received additional bicycles and parts will need to move aggressively to continuously secure parts and develop a more rapid repair system than they had previously. In addition, supplies such as ORS packets, contraceptives and simple drugs are not equitably distributed and available to all villages (either at the village level or through the appropriate nearby HC or HP). Having stimulated an interest in child spacing, for example, it would be a setback if the MOH is unable to support women seeking assistance.

The specific data available about health status and health experiences in the villages of northern Nsanje district are the direct result of HSA reporting through staff at HC and HP. In one HC, the Health Assistant had prepared wall charts outlining key information about every village in the area, and could readily identify data gaps, or trends. At another site, the HA complained that no additional staff were provided to supervise the ADRA HSAs, and he showed little or no interest in the information which might be reported to him by these individuals. Similarly, some HCs were actively using HSAs and the village volunteers in the management of U5 or other clinics, and looked for information from the village to accompany sick persons brought for more advanced treatment; at other sites, there was no indication of this level of interaction. Throughout the evaluation visit it was clear that accurate numeric information about health was difficult to come by in this district. Documentation as a tool to allow effective deployment of resources in the future should be a continuing concern of the MOH, and the village-HSA-HC link should be nurtured.

# Appendix D: List of Individuals Interviewed

Ministry of Health
Nsanje District Office of Health
Nicholas Saiti, Acting DHO
Snowden Ben Mitochi, DHI
Abigail Rose Bonongwe, Matron

Trinity Hospital, Fatima
Dr. Koen Vanwerwsch
Ms. C. M. Chirwe, Nurse manager (Matron)
Mrs. A. Bande, Community Health Nurse
Miss M. Chongwe, Clinic Department
Mrs. A. Nyawaupe, Clinic Department

Staff of Health Centers/Health Posts as noted on itinerary

Village Headmen, Village Health Volunteers, Village Health Commit-tee Members and Residents of villages as noted on itinerary

Malawi Union of Seventh-day Adventists, Blanytre
Wenson L. Masoka, President

USAID, Malawi Mission, Lilongwe
Mexon Nyivongo

# Appendix E: Surveys and Interviewer Questionnaires

# Child Survival IX
# Nsanje District Malawi
# Final Evaluation Questionnaire

Who did interview:_____ Date:_____

Who was interviewed:_____ Where:_____

What organization is he/she with:_____

1. What relationship does this person have with the ADRA CSIX project?

2. What does this person know about the ADRA CSIX project?

3. In what ways does this person/this person's organization relate with the ADRA CSIX project?

4. What does this person think the goals of the ADRA CSIX project are?

5. How well does this person think the ADRA CSIX project has met its goals?

6. What does this person think are the major health problems of women and young children in the project area?

7. How have these health problems changed in the past three years?

8. What does this person know about supervision of ADRA CSIX project workers?

9. How likely does this person think it is that activities begun by the ADRA CSIX project will be continued?

10. How (and by whom) will these activities be continued?

11. What are the best things about the ADRA CSIX project?

12. How does this person think the ADRA CSIX project could have been improved?

Please write down additional Comments.

# Appendix F: Pipeline Analysis